

# EXHIBIT B

Part 1:	Identify the Claim
<b>1. Who is the current creditor?</b>	<p>United HealthCare Services, Inc., on behalf of itself, parents, affiliates, and subsidiaries.</p> <hr/> <p>Name of the entity to be paid for this claim (including other names the creditor used with the debtor, including d/b/a)</p>
<b>2. Proof of Claim number of previously filed claim, if any, that is superseded by this claim?</b>	<p>Claim number: <u>N/A</u></p>
<b>3. Has anyone else filed a claim on behalf of this creditor?</b>	<p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If yes, please provide the filer and claim number</p> <p>Filer: _____</p> <p>Claim number: _____</p>
<b>4. Last 4 digits of creditor's federal tax identification number (FEIN)?</b>	<p>FEIN: <u>9245</u> ____ ____</p>

Part 2: Contact Info for Notices and Distributions	
<b>1. Who should receive notice?</b>	Name: <u>Thomas C. Mahlum, Esq.</u> First name Middle name Last name
	Title: <u>Partner</u>
	Company: <u>Robins Kaplan LLP</u> Identify the corporate servicer as the company if the authorized agent is a servicer
	Address: <u>800 LaSalle Ave., Ste. 2800</u> Number Street
	<u>Minneapolis MN 55402</u> City State Zip code
	Phone Number: <u>612.349.8500</u>
	E-mail Address: <u>TMahlum@RobinsKaplan.com</u> (required)
	<b>2. Where should distributions be sent?</b>
Title: <u>Partner</u>	
Company: <u>Robins Kaplan LLP</u> Identify the corporate servicer as the company if the authorized agent is a servicer	
Address: <u>800 LaSalle Ave., Ste. 2800</u> Number Street	
<u>Minneapolis MN 55402</u> City State Zip code	
Phone Number: <u>612.349.8500</u>	
E-mail Address: <u>TMahlum@RobinsKaplan.com</u> (required)	

<b>Part 3:</b>	<b>Amount of TPP Abatement Claim</b>
<b>1. Total amount of the claim, as calculated by the instructions that begin on page 6 herein.</b>	Claim Amount: \$ <u>\$12,964,957,531.43</u>
<b>2. Components of TPP Abatement Claim, per instructions for calculation.</b>	<p>a. Number of creditor's plan members, subscribers, or covered dependents prescribed drugs identified on NDC List on Appendix A between January 1, 2008 and December 31, 2020. (Note: Count each member only once regardless of the number of prescriptions they had): <u>8,244,043</u></p> <p>b. Number of prescriptions paid by creditor for drugs in item a: <u>48,389,272</u></p> <p>c. Total dollars paid by creditor for such prescriptions <u>\$1,233,235,693.63</u></p> <p>d. Number of plan members in item a who were diagnosed with Opioid Use Disorder (Appendix B): <u>898,040</u></p> <p>e. For members in item d, dollar amount of medical claims with ICD, CPT or HCPS codes (Appendix C): <u>\$11,731,721,837.80</u></p> <p>f. The total number of members, subscribers, and covered dependents covered by your plan or administered by your plan as of January 1, 2021: <u>52,200,000</u></p>
<b>3. If any of the amounts provided in response to Questions 1 or 2 hereof require an explanation, please provide here.</b>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

**Part 4: Sign Below**

**The person completing this TPP Abatement Claim must sign and date it.**

**If you file this claim electronically, FRBP 5005(a)(2) establishes a local rule specifying what a signature is.**

**A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.**

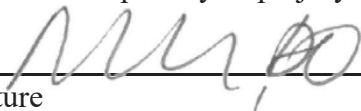
*Check the appropriate box:*

- ☒ I am the creditor  
☐ I am the creditor's attorney or authorized agent

I understand that an authorized signature on this *Third-Party Payor Abatement Claim Form* serves as an acknowledgement and certification that when calculating the amount of the claim, the Third-Party Payor on whose behalf the form is submitted has complied with the TPP Claim Calculation Methodology<sup>1</sup> set forth in the Instructions.

I have examined the information in this *Third-Party Payor Abatement Claim Form* and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

  
 \_\_\_\_\_  
 Signature

**Print the name of the person who is completing and signing this form**

Name: Dr. Rhonda Randall  
 First name Middle name Last name

Title: Chief Medical Officer

Company: United HealthCare Services, Inc.  
 Identify the corporate servicer as the company if the authorized agent is a servicer

Address: 9700 Health Care Lane  
 Number Street

Minnetonka MN 55343  
 City State Zip code

E-mail: prov\_capreport@uhc.com

<sup>1</sup> This is alternatively referred to as the Maximum Eligible Amount Calculation Methodology.